would certainly not dispute the need for public accountability and makes provision for this in various ways. Some 900 local committees throughout the country can take account of any viewpoints expressed and there are opportunities to attend meetings at local and national level. Questions are welcomed at any time and carefully answered. Annual reports and newsletters as well as the inquiry service help to promulgate information about the Campaign's activities.

This is no more than a résumé of the Campaign's reasons for objecting to the tenor of your article, We hope that it will be adequate to show that there is a very real difference between your interpretation of the Campaign's priorities and the aims the Campaign itself sees as being of overriding importance.

NIGEL H KEMP
Scientific Secretary
DAVID GRIBBIN
Secretary General

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SIR,—We have read your leader on medical charities and prevention with considerable interest.

Although the British Heart Foundation raises its funds mainly for research, it keeps the subject of educating the public under continuous review and seeks the opinions of the profession both within its committees and outside. To this end, the foundation sought by letter the opinion of 50 leading British cardiologists about what they would advise their patients who asked how they could prevent a heart attack. Apart from smoking, there was no unanimity of opinion in relation to the other risk factors. It would therefore clearly be irresponsible of the British Heart Foundation to publicise views which had not the backing of the medical profession as a whole.

The British Heart Foundation does, however, publish a series of non-controversial booklets on various aspects of heart disease which are available on request by members of the public and are freely available at the meetings held throughout the country by our regional organisers. Last year over 119000 were distributed. The foundation has also sponsored a cookery book, *Cooking for your heart's content*, which is available to members of the public whose doctors have advised a low-cholesterol diet.

The research funds committee, responsible for the awarding of grants, is made up of experts representing the various disciplines concerned with cardiovascular disease and chaired by an eminent member of the profession who is not a cardiologist. Epidemiology is at present represented by one of our leading epidemiologists, and all applications in this field are carefully reviewed by external and internal assessors and by the research funds committee as a whole.

Finally, we should like to point out that the appeal advertisements are clearly worded for "heart research" and the success of the foundation, in monetary terms, over the last few years is perhaps indicative of what individual members of the public want when they donate their money.

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Chairman of Council
J P SHILLINGFORD
Vice-Chairman of Council

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Comfort versus independence in child development

SIR,—I was most interested to read Dr Martin Schweiger's Personal View (12 January, p 107) and feel that many people who have worked in developing countries will share his sentiments. I wonder if I might offer some of my own observations on the question of child-rearing practices based on my experience in Tanzania?

If in this country a school-age child is seen sucking its thumb, biting its nails, or clutching its cuddly toy, one takes it as a possible indicator of stress. Yet we seem to think it acceptable and almost as a sign of normal development in the preschool child. Mothers are often recommended to encourage their infants to use such comforters to help them feel secure; yet the security for which the child craves is its mother.

In Tanzania such thumb sucking and the use of cuddly toys was not apparent at any age, which leads one to ask whether even in the preschool child its prevalence in this country may be an indication of stress, and whether our child rearing practices are not ideal. In many developing countries the child is closely attached to its mother at all times and breast-feeding into the third year of life is in no way unusual.

How often in an outpatient clinic here one meets parents who admit with guilt or at least embarrassment that their cherished infant sleeps in the same room with them. How do the neighbours react when a 2-year-old runs in from play for a breast-feed? Indeed, how do we and the health visitors feel about it?

We seem in this country to feel that we must teach our children how to become independent by making them sleep alone from a very early age and find comfort away from the breast. Yet independence is a natural stage of development, arriving in its own good time and probably better achieved by a less prematurely stressed child. Is it really that we want the child to be independent, or that the mother wants her independence from the child?

I am not suggesting that all mothers in our society would find it possible or desirable to rear their infants in the same way as a Tanzanian mother. Those who try, however, should not be made to feel abnormal, but encouraged in what may be a method more beneficial to the child.

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Dietary fibre and blood pressure

SIR,—Angela Wright and others (15 December, p 1541) suggest that dietary fibre has a blood-pressure-lowering effect. Their results from 94 university staff and students divided into two groups according to their daily intake of fibre showed that the group with the higher intake had both a lower mean systolic blood pressure and a lower mean diastolic blood pressure. If we assume that their observed systolic and diastolic blood pressures followed a normal distribution in both fibre groups, and use their calculated means and standard errors, it is unlikely that more than two (2·5%) of their subjects had a systolic pressure greater than 140 mm Hg or a diastolic pressure greater than 90 mm Hg. Thus although they showed a shift to the right in distribution of both systolic and diastolic pressure in the lower fibre group the blood pressures in this group were within the accepted physiological range.

We have examined the daily intake of dietary fibre from cereal sources in 112 middle-aged men working in industry, and examined the relationship between cereal fibre intake to both systolic and diastolic pressure (table). The method used to estimate

Differences in intake of dietary fibre from cereal foods (DCF) in 112 subjects grouped by systolic blood pressure

Blood pressure (mm Hg)	No	Mean (±SD) DCF intake (g/day)
	Systolic	
≤109	4	6·94±1·21
110-119	11	5·87±1·59
120-129	28	9·48±4·86
130-139	27	9·19±4·79
140-149	19	9·17±4·47
150-159	11	9·92±6·61
≥160	12	8·18±3·10
	Diastolic	
≤69	6	10·18±4·23
70-79	36	8·54±4·95
80-89	37	8·77±4·91
90-99	18	9·17±6·41
100-109	10	7·87±2·21
≥110	5	9·29±3·26

intake of cereal fibre (to be published elsewhere) was a four-day consecutive unweighed record, which is suitable for distinguishing the intake of individuals. Our results in this homogeneous population over a wide range of blood pressures lend no support to the suggestion of Angela Wright and her colleagues of an association between a low cereal fibre intake and hypertension. They also suggested that their finding might explain why Morris *et al*[1] found a decreased risk for coronary heart disease in those with a high intake of cereal fibre, despite the fact that Morris *et al* stated in their paper, "No association was found between blood pressure and the nutrient factors studied."

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[1] Morris JN, Marr JW, Clayton DG. *Br J Med* 1977; 2:1307-14.

The need for gynaecological oncology units

SIR,—Your leading article on cancer chemotherapy (24 November, p 1312) highlights some of the very real and aggravating problems confronting cancer patients and their medical attendants, be they surgeons or physicians. It raises the point of specialist centres and this needs emphasising. Complex and indeed dangerous agents, often in combination, are now employed and are significantly improving the outcome for many patients whose condition was previously considered hopeless. These agents may be used in conjunction with radical surgery. After all, even when ovarian carcinoma is not considered totally resectable surgery is often necessary as a debulking procedure. The aim is to reduce the total tumour volume and to leave no masses over 1 cm in diameter in the abdominal cavity at the end of the procedure.

Experience in America has shown that units specialising in this kind of work not only have better results than more general units but are more capable of combating problems that may arise from treatment. In no field of cancer is